Cranial Sacral Therapy Center

Patient Name (first) _____ (last)_____ (M.I.) _____

Parent/Guardian Name (first) _____ (last)_____ (M.I.) _____

Home/Cell Phone # _____ Home/Cell Best # _____

I give permission to CSTC to call and leave personal information at the above "best" telephone number. _____ (Initial)

Address:_____ City: _____ State: ___ Zip:_____

Email Address: _____DOB: _____

Emergency contact: _____ Relationship:_____ Phone:_____

How did you hear about us: _____

RELEASE OF INFORMATION

I give permission to the Cranial Sacral Therapy Center ("CSTC") to release information to other healthcare providers, my insurance company, attorney, assignees and/or beneficiaries. _____ (Initial)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have read and understand the HIPAA guidelines. A copy is available at my request. _____ (Initial)

RELEASE OF LIABILITY (legal representative/patient)

I release CSTC from any liability for injury or damages while using the facilities located at 138 Stockton Avenue, San Jose, CA 95126. CSTC will not be subjected to any claim, demand, injury or damages whatsoever, including, without any limitation to those damages resulting from acts of active or passive negligence, except for the sole negligence or willful misconduct, on the part of CSTC, their owners, officers, agents or employees. The patient, for himself/herself and on behalf of his/her executors, administrators, heirs assigns and successors does hereby expressly forever release and discharge CSTC, its owners, officers, employees, agents, assigns and successors from all such claims, demands, injuries, damages, actions or causes of action. I also agree that CSTC is not responsible or liable to patients for articles damaged, lost or stolen in or about the facility. _____ (Initial)

CANCELLATION POLICY:

We respectfully request a 24 hour notice of cancellation. If you have an emergency and cannot provide a 24 hour notice, please call as soon as possible and leave a message on our answering machine. Cancellations without 24 hour notice will be charged a $50 cancellation fee, payable at your next visit.

_____ (Initial)

I willingly consent to the therapy treatment provided by CSTC . _____ (Initial)

My initials above indicate my full participation and agreement for the Cranial Sacral Therapy Center services:

_____ _____

Patient Signature and Date Parent/Guardian Signature and Date

_____ _____

Printed Patient's Name Printed Parent/Guardian Name

Cranial Sacral Therapy Center Patient Intake Questionnaire

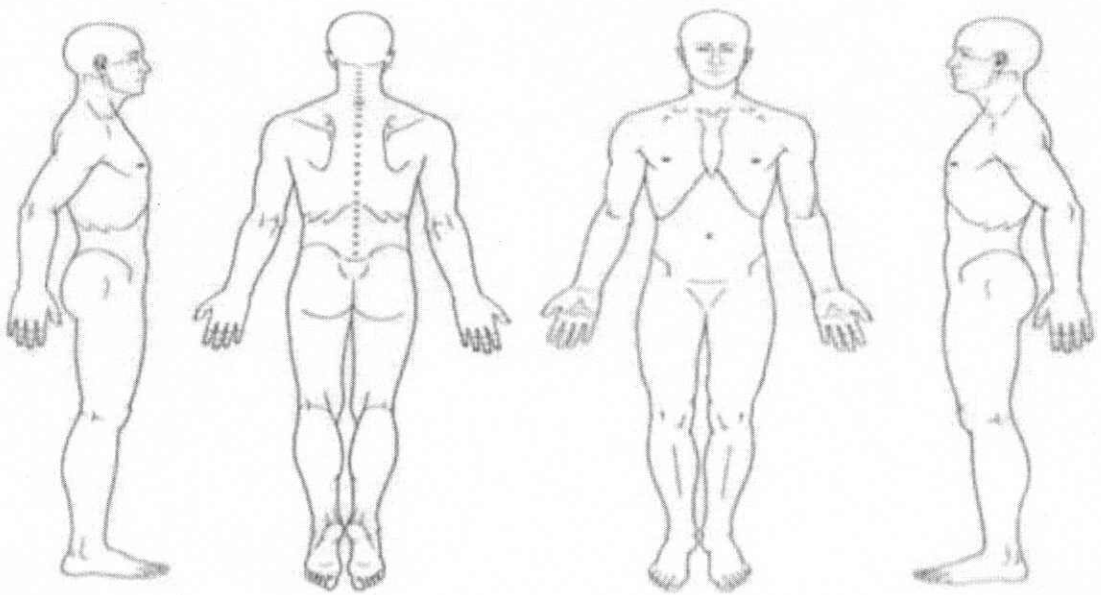
Patient Name:_____ Age:_____ Date of Birth:_____

Date:_____ Occupation/Work activities_____

Currently Working? Yes No Modified Currently a Student? Yes No Modified

Sports/Hobbies: _____

Please indicate your symptoms on the body chart below



How did your Problem begin? (Check all that apply)

___Sudden	___Fall	___Lifting	___Pulling
___Gradually	___Bending	___Twisting	___Auto Accident
___At Work	___Hit from Side	___At Home	___During Sports
___Pushing	___Hit From Behind	___ No Apparent Cause	

Other: _____

When did your Symptoms Begin?_____

Have you had Surgery for this problem? __Yes ___No When?_____

What have you done for treatment thus far?

___Ice ___Heat ___PT ___Stretches ___Chiropractic ___Acupuncture

Other: _____

Medications_____

Is your sleep disrupted?___Yes ___No

Please Prioritize your areas of complaint from body chart above:

Area1:_____
Circle the words that describe the pain:
Pain Ache Stiff Burning
Numb Weak Limited
Motion Sharp
Pounding Pins and Needles

Have they symptoms changed in any way?
____ Better
____ Worse
____ Same

How often is there pain/symptoms?
____ Constantly (100%)
____ Frequently (75%)
____ Intermittently (50%)
____ Occasionally (25%)

Area 2:_____
Circle the words that describe the pain:
Pain Ache Stiff Burning
Numb Weak Limited
Motion Sharp
Pounding Pins and Needles

Have they symptoms changed in any way?
____ Better
____ Worse
____ Same

How often is there pain/symptoms?
____ Constantly (100%)
____ Frequently (75%)
____ Intermittently (50%)
____ Occasionally (25%)

Area 3:_____
Circle the words that describe the pain:
Pain Ache Stiff Burning
Numb Weak Limited
Motion Sharp
Pounding Pins and Needles

Have they symptoms changed in any way?
____ Better
____ Worse
____ Same

How often is there pain/symptoms?
____ Constantly (100%)
____ Frequently (75%)
____ Intermittently (50%)
____ Occasionally (25%)

CRANIAL SACRAL THERAPY CENTER
PRICING POLICY

November 1, 2013

All fees are due at the time of service.

Adults:	
Cranial Sacral Therapy Session (2 hours):	$250-$300
Teenagers age 13 to 18:	
Cranial Sacral Therapy Session (1-1/2 hour):	$200
Children under the age of 12:	
Initial Consult (1 hour):	$125
Follow Up Consult (1 hour):	$100
Homeopathy:	
Initial Consultation (1-1/2 hours to 2 hours)	$375
Follow Up Consultation (30 to 45 min)	$75
Brief Consult in the office or on the phone (15 to 25 min)	$50
Joint Appointment with Kathleen (1 hour)	$50
Neurofeedback	$150
Neurofield	
QEEG	$500
Sessions	$100-$200
Home/Hospital Visits –	
1-30 miles	Session fee +$100
31-50 miles	Session fee + $125

I have read and understand the fees for services policy:

_____ _____

Patient Name Date

_____ _____

Person Financially Responsible for Account Signature

For Office Use Only:

☐	97140 Manual Therapy	☐	723.1 Cervical	☐	_____
☐	90901 Bio Feedback	☐	724.2 Thoracic Spine	☐	_____
☐	Homeopathy	☐	784.0 Lumbar	☐	_____
☐	_____	☐	Headaches	☐	_____
☐	_____	☐	_____	☐	_____

Notes:

CRANIAL SACRAL THERAPY CENTER
CREDIT CARD AUTHORIZATION FORM

_____

Patient Name

_____

Name of Person Financially Responsible for the Account

I authorize the Cranial Sacral Therapy Center to charge the credit card listed below for all services and products provided to me.

Credit Card Type: ☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMEX

_____

Credit Card Number

_____ _____

Security Code Expiration Date

_____

Billing Address City State Zip Code

_____

Card Member Signature